

August 11, 2004

Senator Lloyd R. LaFountain III
Representative Christopher P. O'Neil
Joint Standing Committee on Insurance and Financial Services
100 State House Station
Augusta, ME 04333-0003

Re: Year 2003 Insurance Fraud Report

Dear Senator LaFountain, Representative O'Neil, and members of the Committee:

Pursuant to 24-A M.R.S.A. §2186, this letter constitutes the Bureau's annual report on Insurance Fraud to the Joint Standing Committee on Insurance and Financial Services.

This is the fifth year that insurers have been required to report on insurance fraud and abuse activities in Maine¹. For the year ending 2003, 1,007 insurers filed reports with the Bureau. This is a significant increase over the approximately 450 companies that filed last year. The Bureau has taken measures to ensure reporting compliance by adding a reminder to the Annual Statement Instructions, offering completely automated on-line reporting, and sending reminder letters to some delinquent insurers. This is the first year that the Bureau has approached 100% reporting compliance²

As a result of the increased reporting for 2003, it is difficult to discern any particular trends from the aggregate statistics developed. The report reflects, in a number

¹ For purposes of this report, "Fraudulent Insurance Act" has the same meaning as in 24-A M.R.S.A. §2186, sub-§1, paragraph A.

It includes the presentation or preparation of any information as to a material fact with knowledge or belief that the information will be presented by or on behalf of an insured, claimant or applicant to a person engaged in the business of insurance regarding an application for insurance or for policy renewal, the rating of an insurance policy, a claim for benefits, payments made in accordance with an insurance policy or premium paid on an insurance policy

² For the purposes of this report, "Insurer" has the same meaning as in 24-A M.R.S.A. § 2186, sub §1, paragraph B.

"Insurer" means an authorized insurance company, reinsurer, surplus lines insurer, unauthorized insurer, nonprofit hospital and medical service organization, health maintenance organization, risk retention group or multiple employer welfare organization. "Insurer" also includes an insurance producer or other person acting on the behalf of an insurer. For the purposes of this section, "insurer" also means the state Medicaid program.

of categories, significant increases which could be attributed to any number of factors. However, the precise cause cannot be ascertained due to spotty reporting in the past. In an effort to determine information as to possible trends the Bureau analyzed the top five writers' reports (in terms of direct written premiums) in Maine for the following lines of business for the past five years: workers' compensation; auto (personal and commercial); general liability; property (including homeowner's); and health (including indemnity and HMO). We found that the following reporting trends of the top five writers were not unlike the rest of the group:

- Reporting in the past has not been consistent. If the top writers failed to report for the past few years and then reported in 2003 or skipped reporting one year, it is reasonable to assume that is why some of the numbers increased. An insurer writing more business is likely to have more fraud reported.
- To the extent any numbers were reported, they stayed steady, had a modest reduction, or had a modest increase. We do not see significant increases in reported fraud for the top five writers.

As we move forward from 2003, we will continue with improved compliance and will continue working closely with companies to assure a reasonable level of credibility to the numbers. Thus, over the next 3-5 years we will be able to discern a more statistically valid trend and the numbers will prove more meaningful.

National studies conducted by the Insurance Research Council (IRC) show that auto insurance, workers' compensation and health insurance are the lines that are most vulnerable to fraud. The IRC estimates that one-third of all bodily injury claims from auto accidents contain some amount of fraud, usually in terms of padding or exaggerating a claim, but only 3% are totally fraudulent such as staged accidents. Another form of fraud, lying on applications in order to reduce premium, costs auto insurers \$13.7 billion annually (Insurance Information Institute, or III). According to the Bureau of Insurance's 2003 survey results, there were only 34 cases in Maine where an insurance company was provided with incorrect information to obtain a policy or reduce an insurance premium.

According to our fraud survey, the most common form of workers' compensation fraud in Maine is a faked or exaggerated injury. Other forms of workers compensation fraud are employers who misrepresent the nature of their employees work or under report the number of employees or payroll figures in order to reduce their insurance premiums and medical providers that bill for more expensive products or procedures than those that were provided (III).

As to healthcare fraud, the Health Insurance Association of America (HIAA) states that 80% of healthcare fraud is committed by medical providers, 10% by consumers and 10% by other parties. Medicare/Medicaid fraud is a "huge" part of health insurance fraud (III). In late 1999 the Governmental Accounting Office found that organized crime is heavily involved in health insurance fraud and that the criminals identified were not health care workers, per say, but individuals already prosecuted for securities fraud, forgery and auto theft. With the enactment of HIPAA (Health Insurance

Portability and Accountability Act of 1996) detection and prosecution of health insurance fraud received a boost. The Department of Justice calls health care fraud and abuse its number two law enforcement priority, after violent crimes. In 1996, according to the FBI, Congress provided an added \$54 million over seven years for health care fraud enforcement.

Property, in our survey this year, had the third highest fraud and abuse count by line of business at 190 reported cases. According to the National Fire Protection Association, arson or suspected arson account for nearly 500,000 fires each year, or one in four fires in the United States. Arson and suspected arson are the largest causes of property damage in the U.S.

Despite what may appear to be a bleak picture, a number of tools exist for combating fraud. At the federal level several laws are used to address fraud. These include: The Federal Mail Fraud Statute, the Racketeer Influenced and Corrupt Organizations (RICO) and the Health Insurance Portability and Accountability Act (HIPAA). Also, the Violent Crime Control and Law Enforcement Act of 1994 makes insurance fraud a federal crime when it affects interstate commerce. Since more than half of the top five writers in Maine discussed above are not Maine domestic companies and all are national writers, federal laws play a significant role in fighting fraud for these companies.

There are also several Maine laws that address insurance fraud. Maine is one of only 16 states that require all insurers to have an unlimited fraud plan in place for all lines of business the insurer writes. These fraud plans must outline specific procedures to prevent, detect and investigate all forms of insurance fraud, educate appropriate employees on the antifraud plan and fraud detection, provide for the hiring or contracting for fraud investigations, and report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud.³ All insurers (except reinsurers) must also place a fraud warning on all application and claim forms that states “It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.”⁴

Certain state agencies work with insurers to address fraud, as well. The Workers’ Compensation Board’s Fraud and Abuse Unit tackles issues such as fakes or exaggerated injuries, the Fire Marshal’s Office investigates possible arson, and the Department of Human Services takes on Medicare and Medicaid fraud. Recently, one DHS employee received the Office of the Inspector General Integrity Award for her investigative and logistical support in a Medicare and Medicaid fraud case in Bangor Federal Court.

Fraud has also gotten the attention of the National Association of Insurance Commissioners (NAIC), which encourages the insurance industry to take a proactive role in controlling fraud. The NAIC offers states support through their Antifraud Task Force.

³ Title 24-A, M.R.S.A., Chapter 23, § 2186(5)

⁴ Title 24-A, M.R.S.A., Chapter 23, § 2186(3)

The mission of the Antifraud Task Force is to serve the public interest by assisting state insurance supervisory officials, individually and collectively, in the following fundamental antifraud activities:

- Promotion of the public interest through the detection, monitoring and appropriate referral for investigation of insurance crime, both by and against consumers.
- Provision of assistance to the insurance regulatory community through the maintenance and improvement of electronic databases regarding fraudulent insurance activities.
- Disseminate the results of research and analysis of insurance fraud trends as well as case-specific analysis to the insurance regulatory community and state and federal law enforcement agencies.
- Provision of the liaison function between insurance regulators, law enforcement and other specific antifraud organizations.

Highlights of the 2004 charges of the Antifraud Task Force include: compile and maintain detailed information on antifraud databases maintained by antifraud organizations, financial regulators, and law enforcement; consider developing further guidelines for use by the industry in determining when suspicious claims should be reported; review industry compliance with antifraud initiatives; develop methods to enhance the investigation and prosecution of financial services fraud; and establish guidelines on the investigation and prosecution of insider insurance industry fraud.⁵

We are pleased that the Bureau of Insurance is receiving greater information and gaining a more detailed understanding of insurance fraud in Maine. In the coming years, this baseline data will enable us to develop an increasingly accurate picture of the extent of insurance fraud and abuse in the state of Maine.

If you have any questions concerning this report, please do not hesitate to contact me.

Sincerely,

Alessandro A. Iuppa
Superintendent

cc: Christine A. Bruenn, Acting Commissioner
Colleen McCarthy Reid, Legislative Analyst

⁵ Source: National Association of Insurance Commissioners

Table One: Five Year Summary

	2003	2002	2001	2000	1999
Automobile	768	516	348	260	262
Workers' Compensation	283	226	464	325	472
General Liability	66	26	33	39	15
Life	3	94	26	31	46
Health	90	46	75	122	72
Inland Marine	5	3	13	11	15
Property	190	72	81	92	89
Other Lines	50	429	486	220	24
Total	1,455	1,412	1,526	1,110	995

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Claimant May Have:

Faked Property Damage	
1999	70
2000	74
2001	63
2002	34
2003	316 ¹

Inflated Financial Loss	
1999	65
2000	58
2001	101
2002	45 ²
2003	150

Faked/Exaggerated Injury	
1999	530
2000	463
2001	374
2002	183 ²
2003	539

Staged Accident/Injury	
1999	21
2000	20
2001	47
2002	21
2003	38

Been Known To File Suspect Claims, Including Faking, Exaggerating, or Extending Total or Partial Disability	
1999	53
2000	42
2001	78
2002	21
2003	60

Other	
1999	82
2000	157
2001	190
2002	510 ³
2003	187

Legal Provider May Have:

Hired or Paid Cappers/Chasers to Recruit Clients	
1999	2
2000	0
2001	0
2002	0
2003	0

Charged Fees Inconsistent with Services Provided	
1999	0
2000	0
2001	11
2002	0
2003	0

Other	
1999	4
2000	1
2001	0
2002	1
2003	1

Medical Provider May Have:

Provided an Inaccurate /Incomplete History	
1999	4
2000	6
2001	4
2002	0
2003	1

Billed for Services Not Provided	
1999	10
2000	15
2001	13
2002	2
2003	26

Upcoded or Billed for Excessive Treatments	
1999	233 ⁴
2000	10
2001	24
2002	8
2003	23

Unbundled Services	
1999	1
2000	2
2001	0
2002	2
2003	1

Received Compensation for Referral to Medical or Legal Providers	
1999	3
2000	1
2001	0
2002	0
2003	0

Hired or Paid Cappers/Chasers to Recruit Clients	
1999	10
2000	0
2001	0
2002	0
2003	0

Fabricated Services	
1999	3
2000	0
2001	11
2002	4
2003	10

Provided an Inaccurate/Incomplete History	
1999	0
2000	2
2001	1
2002	0
2003	0

Operated Without a License	
1999	0
2000	0
2001	1
2002	3
2003	1

Other	
1999	11
2000	7
2001	12
2002	11
2003	15

Other Person or Entity May Have:

Received/Paid Compensation for Referral	
1999	1
2000	0
2001	0
2002	0
2003	0

Fabricated Services	
1999	10
2000	1
2001	3
2002	1
2003	0

Charged Inconsistent with Services Provided	
1999	10
2000	10
2001	3
2002	0
2003	17

Provided an Inaccurate/Incomplete History, or Submitted False or Inaccurate Information to Obtain an Insurance Policy or to Reduce an Insurance Premium	
1999	16
2000	11
2001	5
2002	29
2003	34

Other	
1999	18
2000	16
2001	12
2002	20
2003	13

Total Number of Suspected Fraud Claims by Line of Business:

Auto	
1999	262
2000	260
2001	348
2002	516
2003	768

Workers' Compensation	
1999	472
2000	325
2001	464
2002	226
2003	283

General Liability	
1999	15
2000	39
2001	33
2002	94
2003	66

Life	
1999	46
2000	31
2001	26
2002	94 ⁵
2003	3

Health (Including Medicare/Medicaid)	
1999	72
2000	122
2001	75
2002	46
2003	90

Inland Marine	
1999	15
2000	11
2001	13
2002	3
2003	5

Property	
1999	89
2000	92
2001	81
2002	72
2003	190

Other	
1999	24
2000	220
2001	486
2002	429 ⁵
2003	50

Total Number of Suspected Fraud Claims by Type of Insurance:

Personal	
1999	432
2000	626
2001	906
2002	712
2003	971

Commercial	
1999	563
2000	464
2001	622
2002	369
2003	387

Number of Cases Reported/Referred to Law Enforcement Agency:

District Attorney's Office	
1999	4
2000	34 ⁶
2001	4
2002	63 ⁶
2003	4

U.S. Attorney's Office	
1999	2
2000	5
2001	3
2002	0
2003	7

Other Law Enforcement	
1999	36
2000	16
2001	17
2002	12
2003	13

Workers' Compensation Board Abuse and Fraud Unit	
1999	0
2000	1
2001	1
2002	2 ²
2003	21 ⁷

National Insurance Crime Bureau	
1999	78
2000	95
2001	63
2002	14 ²
2003	109

Other, Including U.S. Postal Authorities	
1999	18
2000	17
2001	149
2002	5 ²
2003	3 ⁷

Amount of Money NOT Paid on Suspected Fraudulent Cases:

Year	Amount
1999	\$8,985,366
2000	\$3,527,186
2001	\$5,646,901
2002	\$4,597,730
2003	\$15,657,053

Notes

¹ An auto insurer with a growing market share in Maine reported that most of its suspected or confirmed fraud within the State of Maine occurs when a person applies for and receives auto coverage over the telephone and then reports a claim within 72 hours of securing coverage. Upon investigation, it is usually found that the accident occurred when the policyholder did not have coverage and lied about when the accident took place in order to have the insurance company pay for the loss. This insurer states that only 1% of its Maine claims were referred to an investigator.

² Several large carriers in Maine did not file reports for year-ending 2002.

³ An auto insurer reported misrepresentations on applications to reduce premium (such as not listing all drivers in the household or not disclosing speeding tickets) in this category in this year but did not report this figure in years prior or subsequent.

⁴ Workers' Compensation carriers were reporting cases where a physician submitted a bill for reimbursement and the amount submitted was higher than that which was allowed by statute. It was determined that the physicians were most likely billing their usual and customary fees, which just happened to be higher than the amount allowed by the Workers' Comp reimbursement tables. This is neither fraud nor abuse and was not reported in subsequent years.

⁵ One national life insurance carrier reported fraud and abuse numbers on a national basis for many years. The Bureau worked with the company and only Maine numbers were filed this year. The company has been advised that in the future it should report Maine- only statistics.

⁶ The same national life insurance carrier referred to in Note 4 would report all outside referrals in one category and this changed between 'District Attorney's Office' and 'Other' from year-to-year. The company has been advised that it needs to report on a consistent basis between years.

⁷ A workers' compensation carrier used to report its outside referrals in the 'Other' category and then changed to the 'Workers' Compensation Board Abuse and Fraud Unit' category in 2003 because it better suited where the referrals were sent. The company will use reporting consistent with 2003 in future years.